State of California Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

LICENSING PROGRAM
1426 Howe Avenue, Suite 54
Sacramento, CA 95825-3236
(916) 263-2382 FAX (916) 263-2567
www.medbd.ca.gov

If you provide only voluntary, unpaid services, meet the requirements below and want to apply for a waiver of the renewal fee, complete the application below. If your medical license is currently delinquent, a payment of all accrued renewal fees, delinquent fee, and penalty fee must be submitted with the application. If your license is current no fee is required.

It is important to remember that the holder of a Voluntary Service license must comply with the Continuing Medical Education (CME) requirements, unless the holder has also applied for and received a CME waiver. If you wish to apply for a CME waiver, you must contact the Board for the appropriate forms. If you are NOT requesting a waiver, complete the CME and Financial Interest Statement on the reverse.

VOLUNTARY SERVICE PHYSICIAN APPLICATION FOR WAIVER FROM PAYMENT OF RENEWAL FEE ***Please print or type.*** ***Illegible applications will be returned.***	**FOR OFFICE USE ONLY** **Fee Paid:** _____ **Receipt #:** _____ **Date Cashiered:** _____ **Cashier's Intl.:** _____ **Date Approved:** _____ **Date Denied:** _____ **Enforcement Approval:** ____Yes ____No **Date:** _____

Name (first, middle, last):	
Address: **Is this address currently on file with the Medical Board as your official address of record? If not, complete reverse.**	
Telephone Number: **FAX Number (if applicable):**	**Telephone** ( ) **FAX** ( )
Social Security Number:	
California Medical License Number:	

Section 2442 of the Business and Professions Code states the renewal fee shall be waived for a physician and surgeon who certifies to the Medical Board of California that license renewal is for the sole purpose of providing voluntary, unpaid service.

I certify under the penalty of perjury under the laws of the State of California that the information contained in this application, including supporting documents, is true and correct and that I am licensed to practice in the State of California.

_____ _____
Applicant's Signature **Date**

All items in this application are mandatory; none are voluntary. This information is requested by the Division of Licensing of the Medical Board of California. Failure to provide any of the requested information will result in this application being rejected as incomplete. The information provided will be used to determine your eligibility for waiver of renewal fees, under Section 2442 of the Business and Professions Code. The Licensing Program Chief is the custodian of records. Access to records by the individual to whom they pertain may be obtained under the Information Practices Act by contacting the custodian of records at the above address. Information in this application may be transferred to other governmental and law enforcement agencies.

Disclosure of your Social Security number (SSN) or Federal Employer Identification Number (FEIN) is mandatory. Section 30 of the Business and Professions Code and Public Law 94.455 (42 USCA 405(c)(2)(C)) authorize collection of your SSN. Your SSN or FEIN will be used for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your SSN or FEIN, your application will not be processed and you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

BOTH SIDES OF THIS FORM MUST BE COMPLETED

CURRENT MAILING ADDRESS

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☐ **Check here if this is a change of address so that your record can be updated. If this is a U.S. Postal Service, P.O. box, you must list a confidential street address.**

FINANCIAL INTEREST AND CME CERTIFICATION STATEMENT

FINANCIAL INTEREST

If you have any financial interest to report, please complete the portion below. If not, check box to right. (Attach additional sheet(s), if necessary.)		**No**

California's Financial Interest Disclosure law (Business and Professions Code Section 2426) requires you to disclose any financial interest that you or your immediate family have in specified health-related facilities located in or outside the State of California. Immediate family means a spouse, child or parent of a licensee, and a spouse of a child of a licensee.

Financial interest includes any type of ownership interest including share or stock ownership, limited partnership interest, debt, loan, lease, compensation, remuneration, general or limited partnership interest, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment of money or anything else of value to a licensee or the licensee's immediate family from a health-related facility.

Health-related facility means any facility providing clinical laboratory services, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, diagnostic imaging, or outpatient surgery centers. Diagnostic imaging includes all x-ray, computed axial tomography, magnetic resonance imaging, nuclear medicine, positron emission tomography, mammography and ultrasound goods and services.

A financial interest does not include the ownership of corporate investment securities, including shares, bonds, or other debt instruments that (1) are purchased from a licensed securities broker on terms available to the general public through a licensed securities exchange or NASDAQ, (2) do not base any profit distributions or other transfers of value on the licensee's referral of patients, (3) does not have a separate class or accounting for any persons or licensees who may make patient referrals to the corporation, and (4) are in a corporation which has total gross assets exceeding $100,000,000.

Health-Related Facility Name(s)	Facility's Address

I certify under the penalty of perjury under the laws of the State of California that I read and understand the enclosed information defining financial interest and that I have disclosed on this application the names of those health-related facilities in which I or my family have a financial interest.

Applicant's Signature_____ **Date**_____

CME CERTIFICATION STATEMENT

In order to insure the continuing competence of licensed physicians and surgeons, the Division of Licensing shall adopt and administer standards for the continuing education of such licensees. The division shall require each licensed physician and surgeon to demonstrate satisfaction of the continuing education requirements at intervals of not less than four nor more than six years.

I certify under the penalty of perjury under the laws of the State of California I read and understand the continuing medical education (CME) requirements, have completed and can document (if audited) an average of 25 hours of approved CME each calendar year, with 100 hours over the last 4 years or that I hold a CME waiver from the Medical Board of California.

Applicant's Signature_____ **Date**_____